Please Return To:
GHP
P.O. Box 5000
McRae, GA 31055

ADJUSTMENT REQUEST FORM

Adjustment Requests must be received within 3 months from the month of Medicaid payment.

1. Transaction Control Number (TCN) / Internal Control Number (ICN) of the **paid** claim to be adjusted as shown on the Remittance Advice

Member Medicaid Information

2. Medicaid Number

Member Name (Last, First, Initial)

3. Provider Name/Address

Provider Number

Phone Number ( )

Contact Person

4. Reason for adjustment (check one box)

A. ☐ Apply COB (indicate amount in Block #5D)
B. ☐ Change information as indicated in Block 5 below
C. ☐ Void claim
D. ☐ Medicare adjustment (attach all EOMB's that apply to this adjustment)

5. Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number enter zero in the line number field. COB applied should always be line #0.

5A Line to be Corrected	5B Information to be Changed	5C From (Current) Information	5D To (Corrected) Information

6. Explanation for Adjustment

7. FOR DCH USE ONLY

CCN _____ FS Line Amount $ _____

Provider Signature _____ Date _____

DMA 501 (1/03)